

TB & HIV Package of Care in South Africa

Dr Vincent Tihon

Enhancing Quality of Care Meeting

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- Rationale and background
- Goal and objectives
- Progress of implementation
- Challenges
- Recommendations

Rationale:

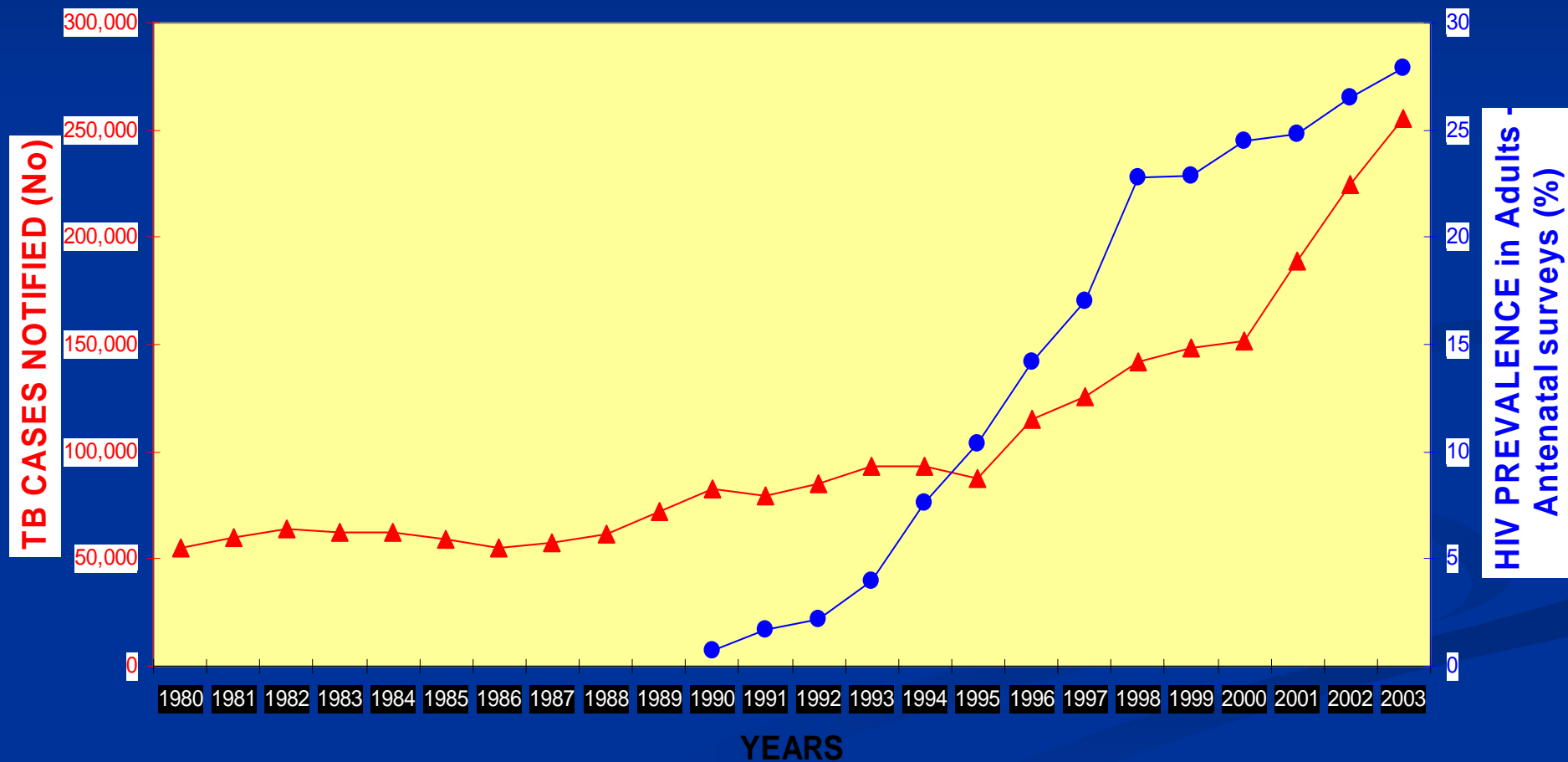
HIV and TB deadly duo

- HIV increases the risk of developing active TB for those who have been infected with TB earlier in life. Risk increases from 10% lifetime to 10% per year
- If newly infected with TB, persons with HIV are more likely to progress to active TB disease
- TB is now the leading cause of death among HIV infected persons

The Burden of TB and HIV in South Africa

- Approximately 6 million South Africans HIV-infected, an estimated 2 million of whom will get TB before they die
- 1,700 new HIV infections per day
- TB cases (incidence 599/100,000) - >300% increase since 1989
- 55% of TB patients are HIV+ (MRC MDR TB Study, 2002)
- TB is the most common opportunistic infection and the biggest killer of people living with HIV/AIDS

TB NOTIFICATION AND HIV PREVALENCE SOUTH AFRICA 1980-2003

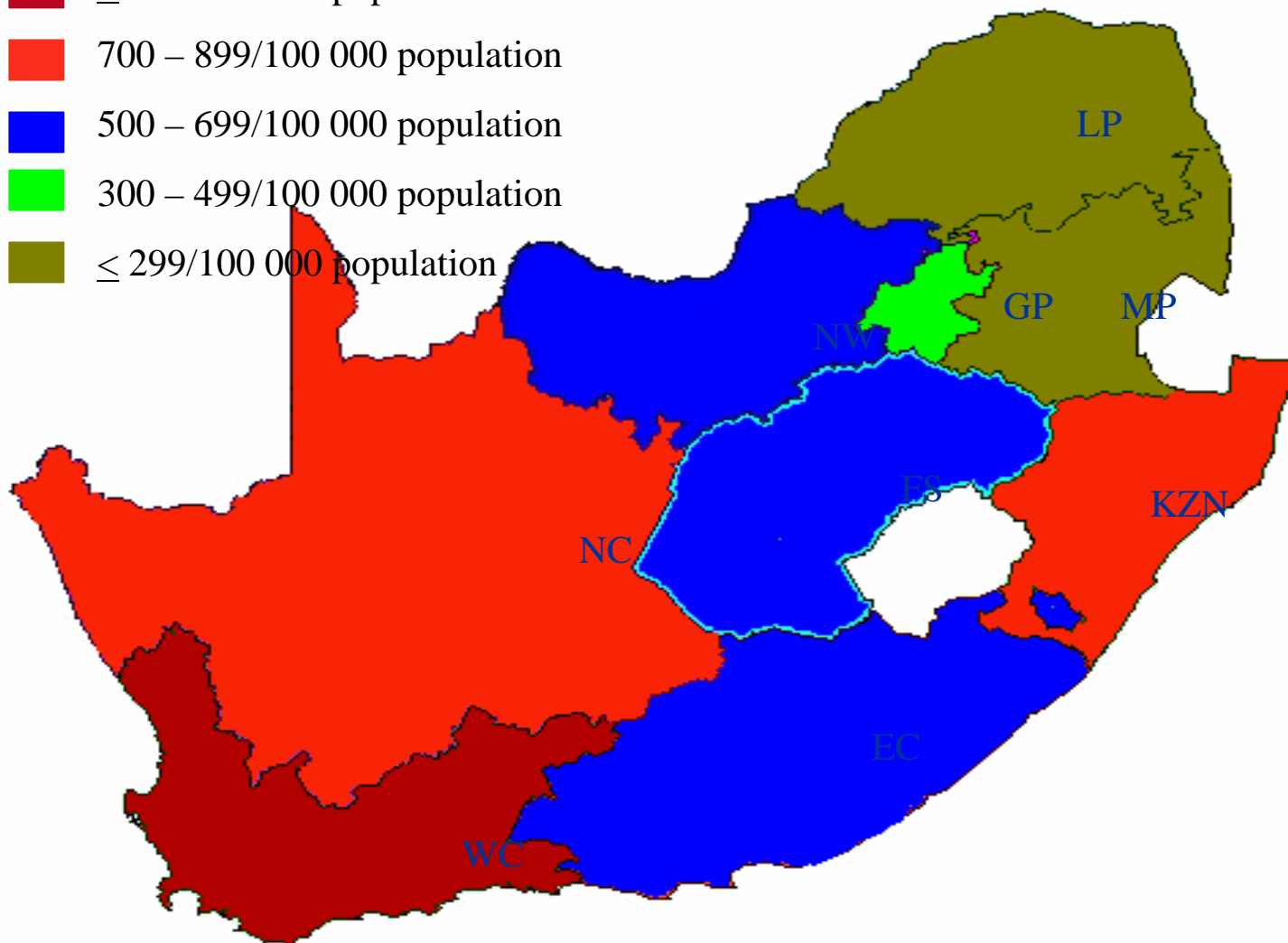


Current Situation (TB)

- Incidence of TB increasing, now 599 cases per 100 000 population (2004)
- Significant increase in number of reported pulmonary TB cases since 1996
- 75% of total burden in KZN, WC, EC, Gauteng
- Cure rates low (54%), defaulter rate high (13%), transfer rate high (9.4%)
- Third of patients not accounted for (defaulters, transfers, not evaluated)

TB incidence in South Africa - 2004

- $\geq 900/100\ 000$ population
- 700 – 899/100 000 population
- 500 – 699/100 000 population
- 300 – 499/100 000 population
- $\leq 299/100\ 000$ population



HIV prevalence and TB incidence

South Africa 2004

PROVINCE	HIV PREVALENCE (% - 2004 ANC)	HIV PREVALENCE IN TB (MRC)*	TB Incidence (2004)
KZN	40.7	64.4	877
Mpumalanga	30.8	67.2	241
Free State	29.5	71.9	667
North West	26.7	66.0	555
Gauteng	33.1	63.8	449
Eastern Cape	28.0	30.5	593
Limpopo	19.3	52.4	215
Northern Cape	17.6		783
Western Cape	15.4	28.2	988
AVERAGE	29.5	55.3	599

* Prevalence of HIV in culture-confirmed TB patients (n=4 639)

Goal of TB&HIV Collaborative Activities

To decrease
the burden of TB and HIV
in co-infected patients

Objectives of TB&HIV Collaborative Activities

A. Establish the mechanism for collaboration between TB&HIV/AIDS programs

- A.1. TB&HIV coordinating bodies
- A.2. HIV surveillance among TB patient
- A.3. TB&HIV planning
- A.4. TB&HIV monitoring and evaluation

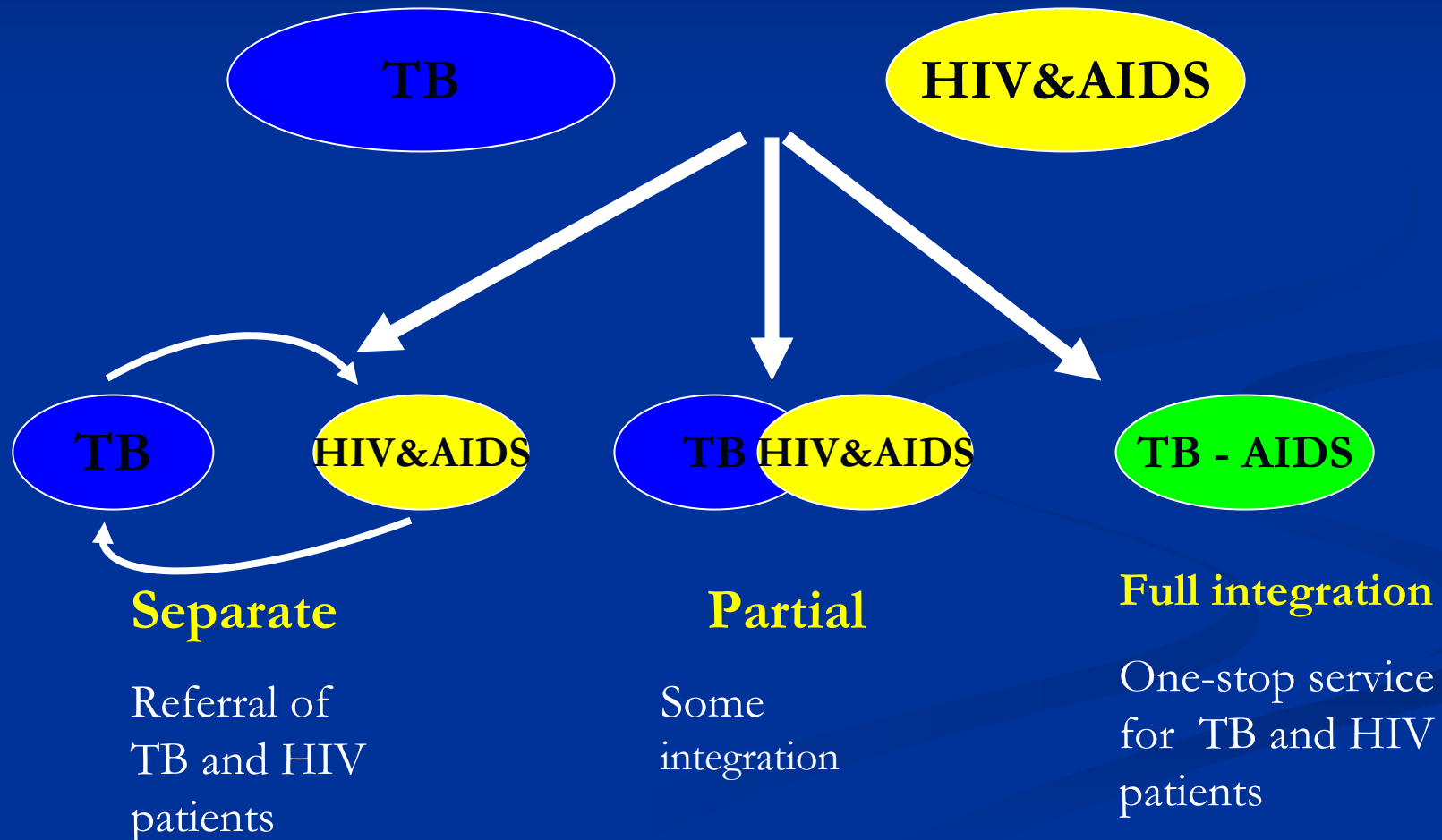
B. To decrease the burden of TB in PLWHA (HIV entry point)

- B.1. Intensified TB case finding
- B.2. Isoniazid preventive therapy
- B.3. TB infection control in care and congregate settings

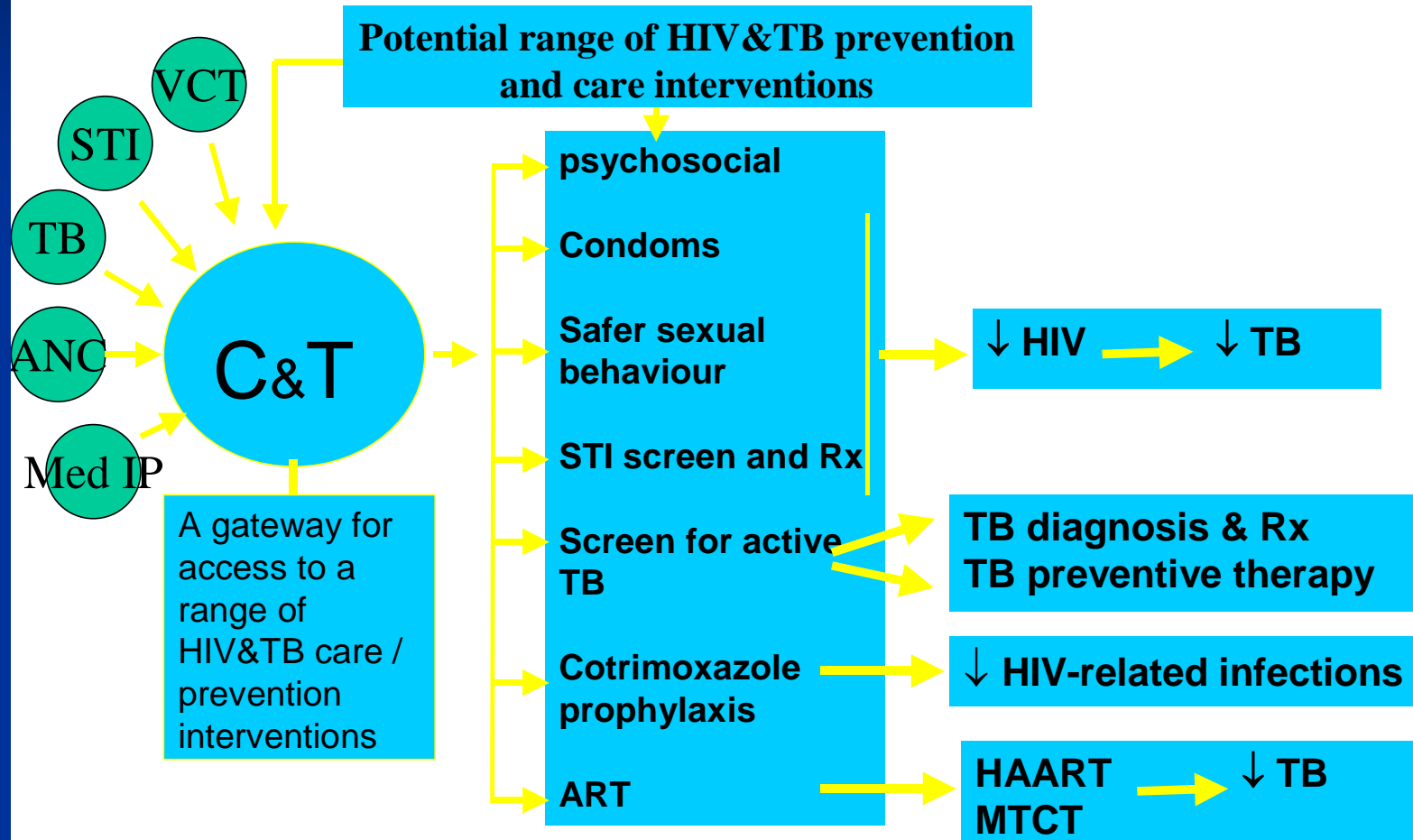
C. To decrease the burden of HIV in TB patients (TB entry point)

- C.1. HIV testing and counselling
- C.2. HIV preventive methods
- C.3. Cotrimoxazole preventive therapy
- C.4. HIV/AIDS care and support
- C.5. Antiretroviral therapy to TB patients.

Which model of collaboration?



Operationalising the link between TB&HIV activities



Phased Approach

- Start with DOTS and STI syndromic management
- Add C&T with rapid HIV testing, active TB case finding and cotrimoxazole prophylaxis +/- IPT
- Add ART for prevention of mother to child transmission and rape survivors
- Add antiretroviral therapy (ART) for treatment of eligible HIV+

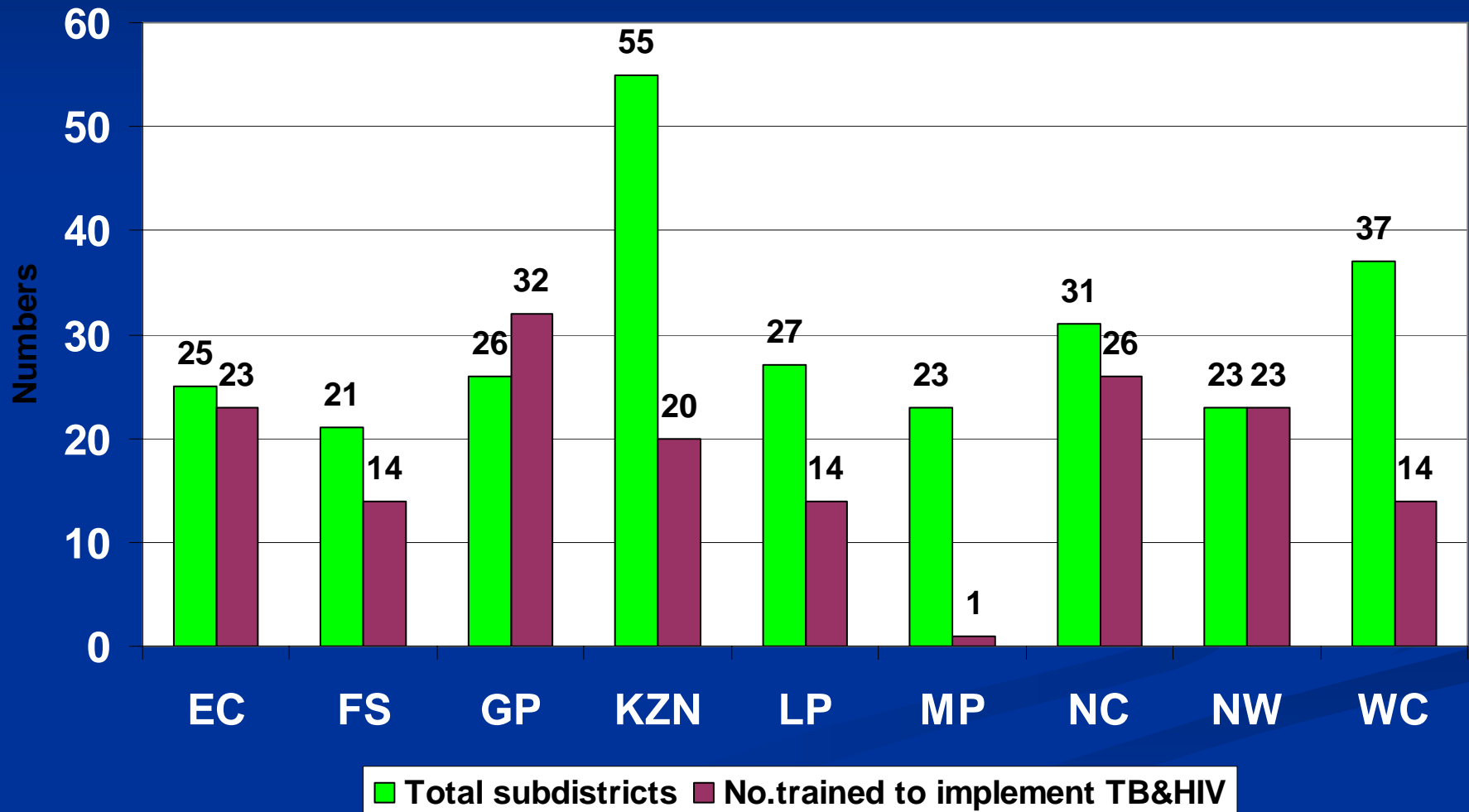
Progress on implementation of the policy

Progress in implementation: TB&HIV Collaboration Training

- 1999: 4 districts (pilots)
- 2001: 13 districts
- 03/2005: 94 sub districts
- 03/2006: 160 sub districts

- 03/2007: 230 sub districts
- 03/2008: 269 sub-districts

SUB-DISTRICTS TRAINED TO IMPLEMENT TB&HIV 2005/06



Issues around expansion

- Coverage within sub-districts varies
- Training \Rightarrow Implementing
- Coordination with other programmes and leadership/ownership
- Quality of service
- Quantitative and qualitative indicators of implementation of package of care
- Community involvement

1. Establish collaboration

- HAST (HIV AIDS STI TB) concept
 - Composition
 - Terms of reference not defined
 - National
 - Use existing meetings – no specific committee
 - Absence of specific joint planning
 - Provincial HAST committees
 - District HAST committees

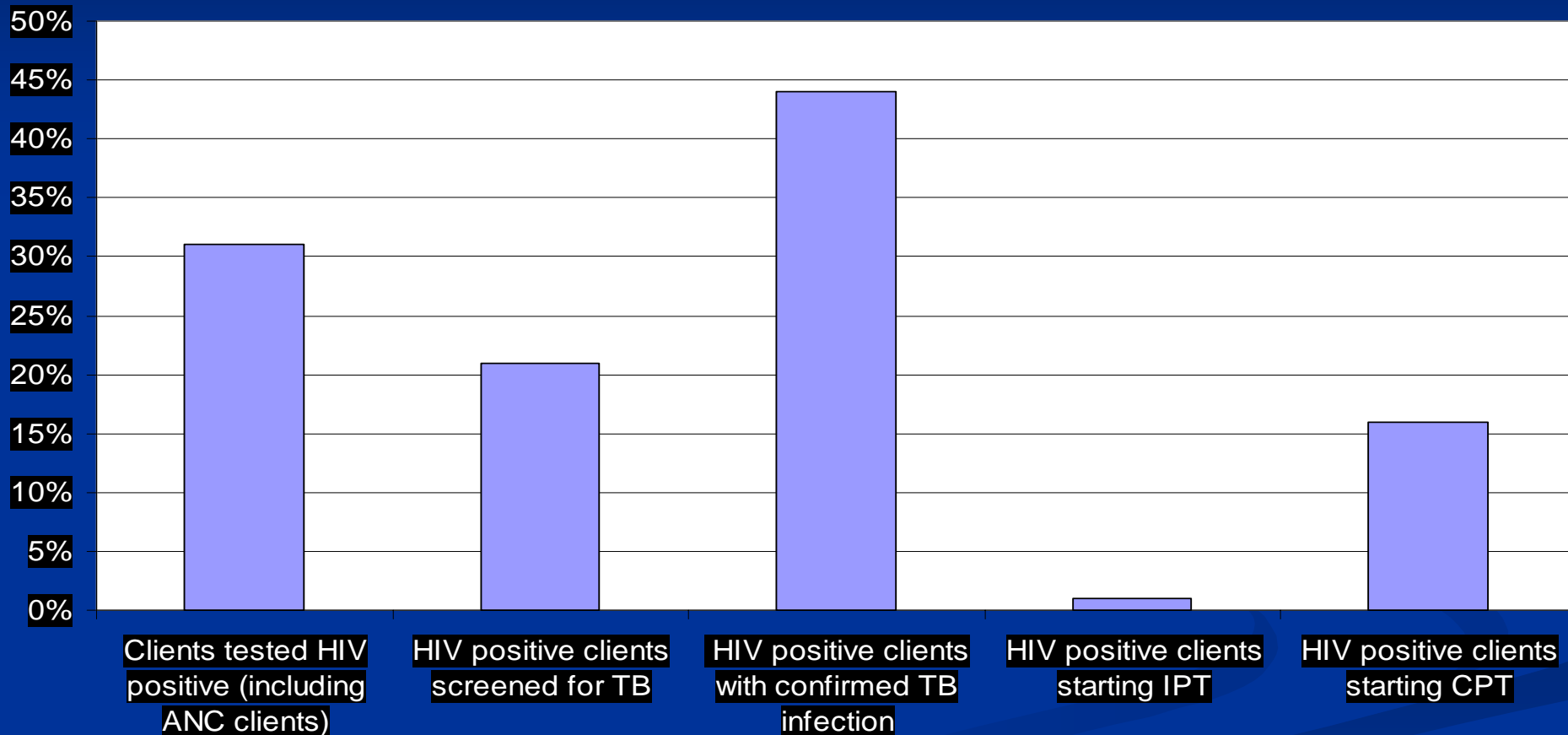
2. Reduction of burden of TB among People Living with HIV&AIDS (HIV entry point)

- Intensified TB case finding
 - At VCT
 - At PMTCT
 - HIV clinics, wellnes centres, ART sites, ...
 - Congregate settings

HIV entry point (cont)

- IPT (Isoniazid preventive therapy)
 - IPT to PPD+ (skin test) HIV infected individuals reduce the risk of developing active TB in the short term to around 40% of what it would have been without such treatment
 - Responsibility of HIV programme
 - National policy exist but slow endorsement by provinces
 - No/slow implementation (only GP)
 - **Main reasons:** no commitment from HIV programme, fear to distract limited resources (HR and finance), fear of growing drug resistance, lack of integration of services, logistical problems (Skin test/Mantoux, availability of INH), difficulty to exclude active TB, quality assurance, burden for patients, etc

Routine data HIV entry point (2004-2005)



Source: TB & HIV reports of 7 provinces

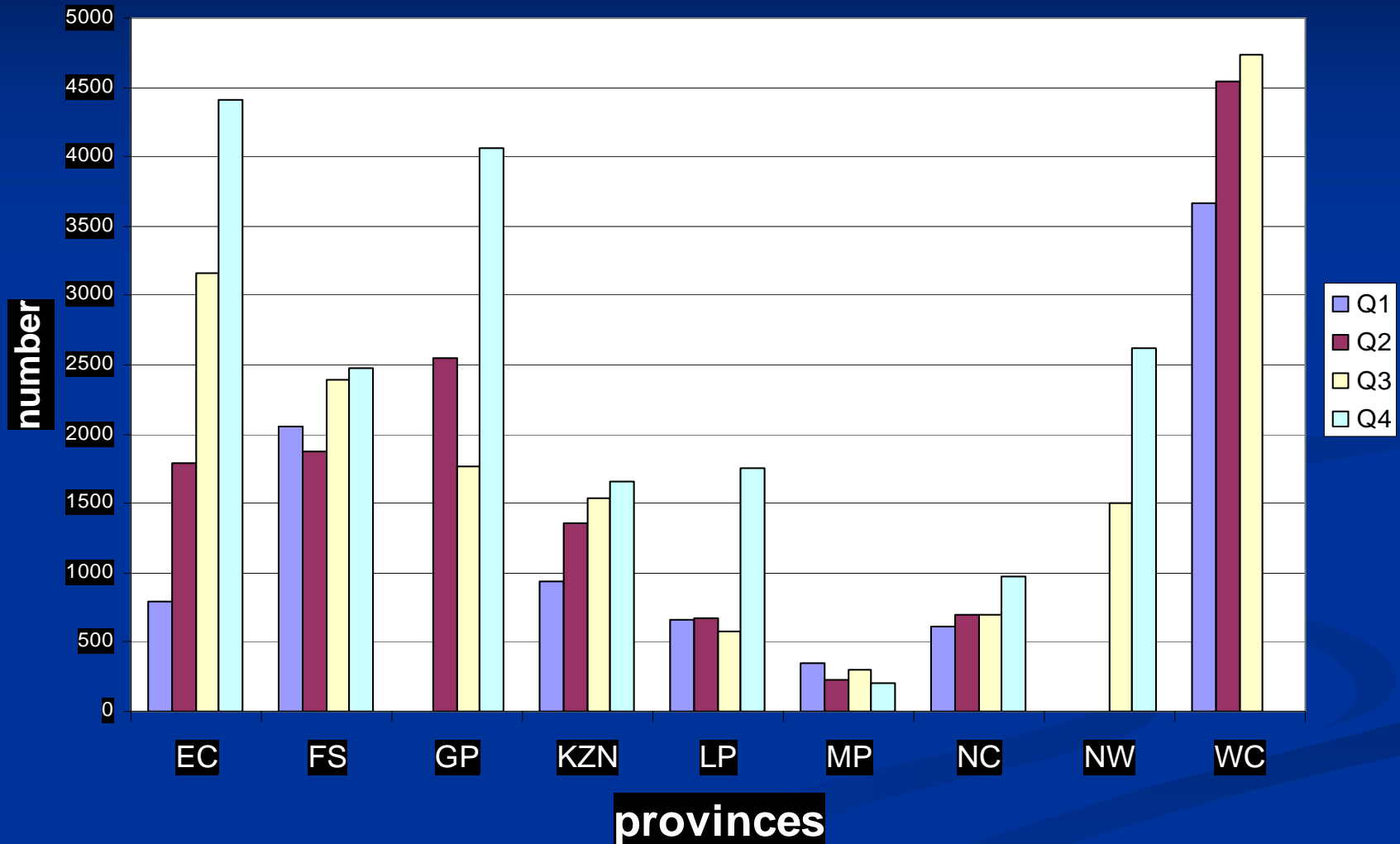
Issues around HIV entry point

- Lack of defined roles and responsibilities for systematic TB screening among HIV infected individuals
- Difficulty diagnosis of TB in HIV (? algorithm)
- Lack of monitoring tool (ie CPT)
- Low implementation of Isoniazid preventive therapy (is IPT an “orphan intervention”?)
- Implementation of CPT

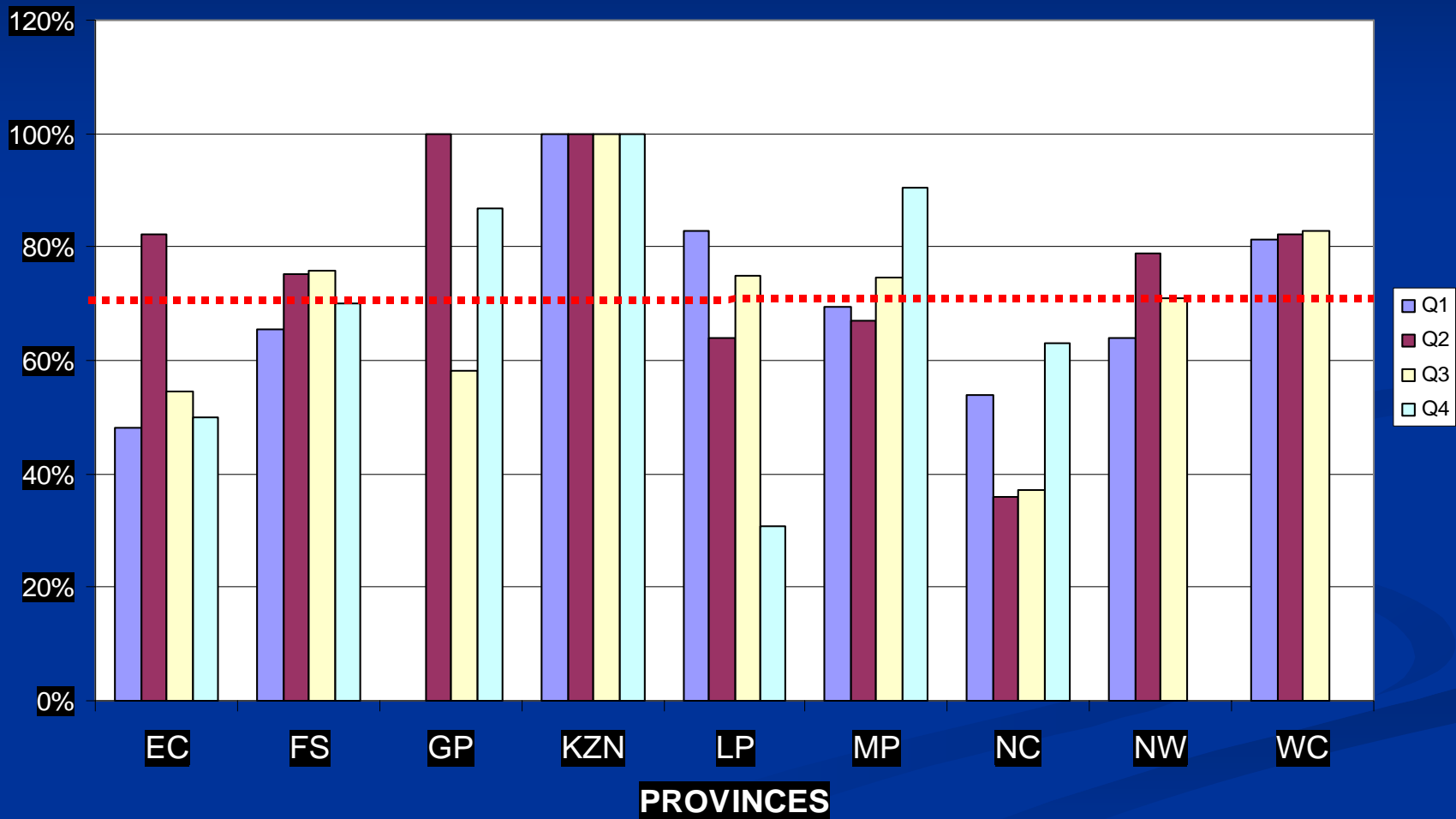
3. Reduction of burden of HIV among TB patients (TB entry point)

- Provision of HIV counselling and testing to TB patients
- Prevention of HIV transmission
- Provision of CPT to co-infected
- Provision of care and support
- Provision of ART to eligible TB patients

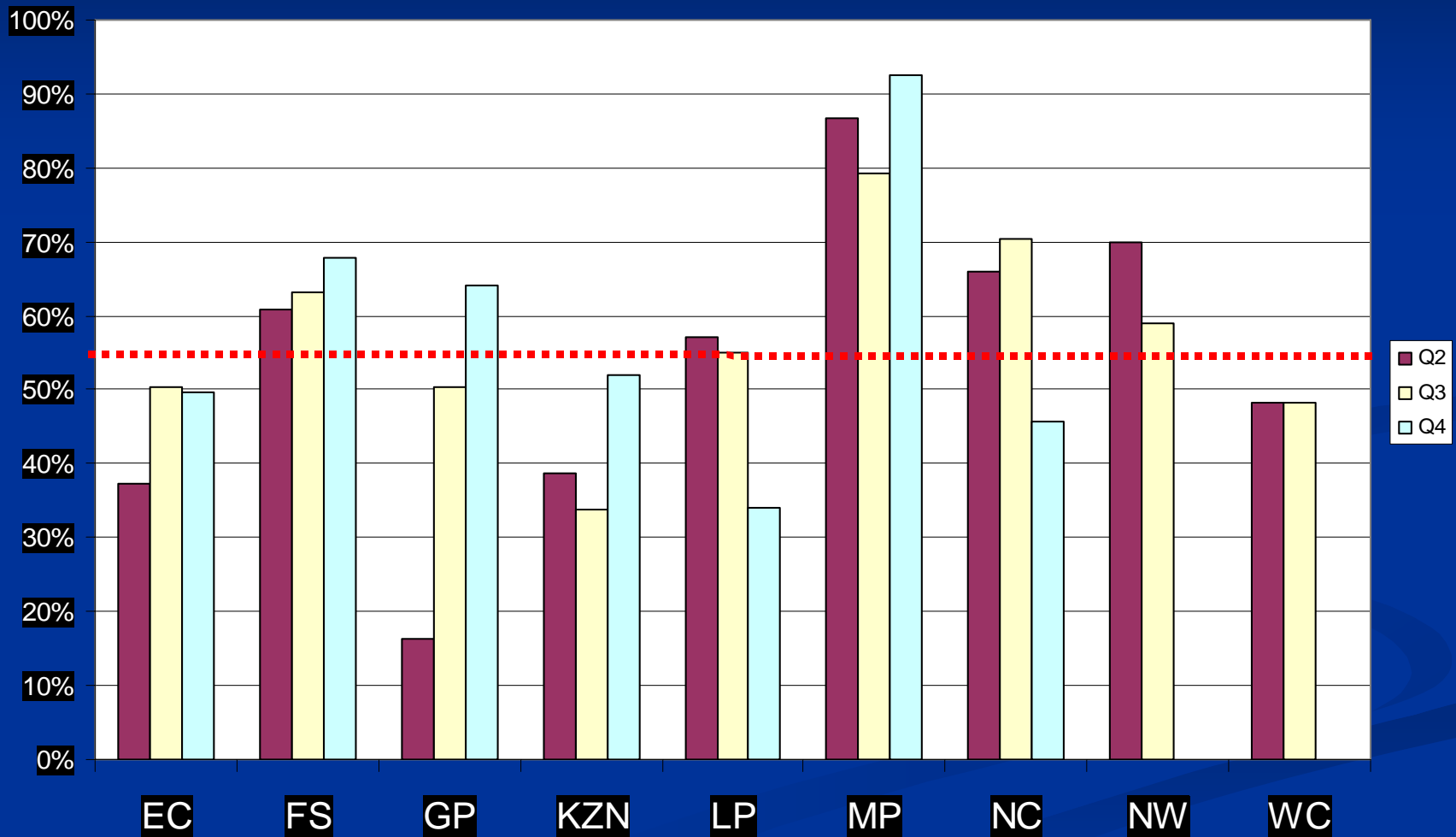
C&T OF TB PATIENTS 2004-5



HIV TEST UPTAKE AMONG C&T OF TB PATIENTS 2004-5



HIV POSITIVITY AMONG TB PATIENTS WHO ACCEPTED TESTING 2004-5



Progress so far

- National & provincial TB&HIV staff appointed
- HAST committees established and strengthened at provincial & district levels
- IPT guidelines part of national ARV guidelines
- Management of co infected patients also included in ART guidelines
- 168 sub districts trained in TB&HIV collaborative activities(target is 160 for 2005/6)
- Expansion of the implementation of TB entry point
- NTCP & TB&HIV unit piloting a tool for HIV surveillance in TB patients (annex register)

Challenges

- Sub optimal collaboration between the 2 programmes
- Lack of defined roles and responsibilities between TB and HIV programmes at all levels
- Lower engagement of HIV programme
- Potential risk for duplication at national and provincial levels in the context of the comprehensive plan
- Human resources (shortage, lack of skills – facility level)
- Structures (space for confidential counselling, increased number of patients,)
- Lack of formal referral systems

Constraints and critical questions

- Screening of TB among HIV
- IPT, CPT – implementation and monitoring
- IPT + ART
- Drug interaction TB – ART
- IRIS
- C&T uptake by TB patients
- Recording and monitoring of data (tools, completion, validation, quality)

Recommendations

- Clarify strategic vision, roles and responsibilities for TB&HIV activities in the context of the comprehensive plan (esp HIV programme)
- Engage senior/district managers to mobilize human & financial resources
- Coordination of staff training (comprehensive prevention, care and support)
- Develop TB&HIV communication strategy
- Engage with private sector (NGOs, CBOs, etc)
- Strengthen monitoring & evaluation
- Operational research

Thank you !